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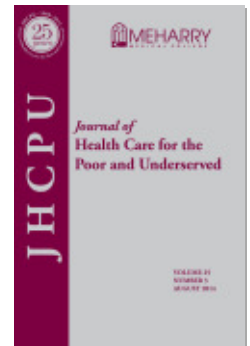
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A Systematic Review of Factors Affecting Migrant Attitudes Towards Seeking Psychological Help

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Abstract: Research indicates that service utilization rates in migrant groups are low, although levels of distress appear high when compared with host populations. This paper systematically reviews quantitative and qualitative literature on factors associated with attitudes toward seeking psychological help among working age migrants. Data were extracted from MEDLINE, EMBASE, PsycINFO, Science Direct and SAGE databases. Eight quantitative studies and 16 qualitative studies met the inclusion and exclusion criteria. The majority of studies were conducted in North America (67%). Although results of quantitative studies were heterogeneous, stronger identification with host than heritage culture, fluency in host country language, psychological attributions of distress, higher educational levels, higher socioeconomic status, female gender, and older age were associated with more favourable attitudes toward help-seeking in some migrant groups. Three major themes emerged from the qualitative literature: logistical barriers, cultural mismatch between service providers and participants, and preferences for other sources of assistance.

Key words: Immigrant, help-seeking, psychological, attitudes.

Immigration is high on the political agenda in the United Kingdom (UK) and other countries.¹ Segal, Mayadas, and Elliott² describe a number of processes integral to the experience of migration. First, public attitudes and social policies in the receiving country are likely to affect ease of transition. It is necessary to navigate bureaucratic systems upon immigration, for instance, by arranging visas and work permits. Immigrants are likely to differ in terms of individual and social resources. Relevant factors include education, vocational skills, literacy, fluency in the host country's language, economic resources, and social networks. Transitions are likely to be smoother if work, accommodation, and health services can be easily accessed.

There is a considerable volume of literature on the impact that the stresses associated with immigration can have on migrants' emotional well-being. Bhugra, Gupta,

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Bhui, *et al.*³ consider that psychological adaptation to migration is influenced by factors including pre-migration adjustment, cultural bereavement, and culture shock. Further, research indicates that migrants may experience lower socioeconomic status, social isolation, and prejudicial treatment, all of which increase the risk of experiencing distress in migrant and minority ethnic groups.^{4,5,6} A review by Lindert, Ocak-Schouler, Heinz, *et al.*⁷ suggests that migrant populations are at least as likely to experience mental health problems as non-migrants, and are at increased risk of suicide and psychosis.

Previous research has examined service utilization in different minority ethnic groups. Much of this literature focuses on specific populations, such as Hispanic and Asian populations in the U.S. (e.g., Bauer, Chen, & Alegria).⁸ However, there are several difficulties with interpreting this literature. Firstly, many papers conflate different generations of immigrants. This is potentially problematic, as the life experiences and cultural identity of first generation immigrants are likely to differ from those of subsequent generations.⁹ Second, the methods employed in previous attempts to integrate literature on issues of help-seeking in immigrant populations have generally been narrative and non-systematic in nature.

Three previous reviews discuss issues pertaining to service utilization in migrant populations in Europe;^{7,10,11} only one of these was a systematic review.¹¹ These reviews suggest that although markers of distress are often elevated in migrant populations relative to host populations, utilization of mental health services is generally lower. Furthermore, pathways to mental health services are more likely to involve involuntary hospital admissions involving the police and emergency services. Similar findings have been reported in studies of other immigrant populations, such as Latino migrants in the U.S. For instance, Alegria, Mulvaney-Day, Woo, *et al.*¹² found that foreign-born Latino participants were less likely to approach services for mental health issues than those born in the U.S. Similarly, Vega and colleagues^{13,14} found that Mexican-born participants utilized formal services for mental health problems less frequently than participants of Mexican descent born in the U.S. Carta, Bernal, Hardoy, *et al.*¹⁰ suggest that obstacles to health care for migrants may include lack of adequate information regarding health care facilities, communication difficulties, stigma, and the structure of the health care system. They also highlight that the quality and availability of mental health services varies among countries.

Service utilization is also likely to be influenced by culturally informed views relating to help-seeking. Drawing upon models such as Azjen's Theory of Planned Behaviour,¹⁵ Henshaw and Freedman-Doan¹⁶ emphasise the importance of studying attitudes and perceptions about mental health services; they suggest that attitudes toward help-seeking predict help-seeking behaviour. Reviews by Henshaw and Freedman-Doan,¹⁶ Prins, Verhaak, Bensing, *et al.*,¹⁷ and Vogel, Wester, and Larson¹⁸ have examined these issues, although their focus is not on migrant populations. Demographic factors that consistently appear to be associated with greater willingness to approach mental health services include female gender, greater severity of distress, and higher educational levels. Evidence on age is not entirely consistent, but it seems that adolescents and older adults may be less likely to seek help than working age migrants. Practical barriers to seeking treatment may include scheduling, treatment costs, and transportation. In addition, psychological factors including stigma, fears about treatment, self-concealment, fear of

emotion, beliefs about treatment effectiveness and risks, social norms, and self-esteem appear to be associated with help-seeking attitudes. Henshaw and Freedman-Doan¹⁶ report an association between beliefs about the cause of distressing experiences and the sources of help sought across cultural groups. For instance, a belief that distress had spiritual causes might lead to seeking help from a religious leader. Vogel, Wester, and Larson¹⁸ also consider that cultural incongruence of mental health services may prevent help-seeking.

This systematic review seeks to evaluate existing literature on voluntary, working age, first generation migrants' attitudes toward seeking help for distress from formal services. Help-seeking attitudes in this context reflect the perceived desirability or undesirability of seeking assistance for distress from formal services. There were several reasons for focusing on working age, first generation, voluntary migrants. Studies of asylum seekers and refugees were not included in the review since these populations are likely to have a different profile from voluntary migrants: in particular, rates of trauma are likely to be higher.¹⁹ Older migrants are likely to be affected by different issues to working age migrants and may apply different strategies for coping with stressors.²⁰ Rumbaut⁹ argues that the strategies that migrants employ to adapt to a new culture and the types of attitudinal shifts that result from this are dependent on age at migration. Due to their developmental level, children may adapt more flexibly to the values of the host culture. Further, the values of the heritage culture are likely to be diluted with each generation of migrants.⁹ Subsequent generations are likely to be exposed to a wide range of cultural influences, and children of migrants may have a mixed cultural heritage. Thus, including only studies of first generation, working age migrants allows the role of cultural transitions to be considered in a focused sample, thus controlling (at least to an extent) for the confounding influences of life stage effects.

Nonetheless, there is still considerable heterogeneity in the samples involved in the various studies included in the review. In particular, the review includes migrants from a wide range of ethnic groups migrating to a range of host countries. These participant groups cannot be considered equivalent. The cultural norms and values of different ethnic groups are likely to vary considerably, including those concerning help-seeking attitudes. In turn, host countries differ not only in their cultural traditions but in health service provision. Factors such as the cultural similarity or divergence between host and heritage culture and health systems may have a considerable impact on help-seeking attitudes. Despite this, it seems worthwhile to investigate whether any general trends in help-seeking attitudes can be discovered in the migrant literature. Further, identification of issues pertinent to specific cultural groups may be helpful in health service development.

Methods

A systematic literature search was undertaken to identify relevant papers examining migrant attitudes toward seeking psychological help. Studies were assessed for quality using criteria developed from existing literature. Data from quantitative studies were summarised in relation to a number of key variables associated with help-seeking attitudes. Results of qualitative studies were integrated using the constant comparative method.²¹

Search strategy. Greenhalgh's²² guidelines on literature searches were used. Databases searched included: EMBASE 1980 to 2008 Week 52; PsycINFO 1806 to December Week 4 2008; and MEDLINE 1950 to November Week 3 2008. In addition to providing citations for journal articles, the PsycINFO database also searches dissertation abstracts, thus broadening the scope of the search. The following search terms were used:

1. *migrant\$1 or immigrant\$1*
2. *mental or psychological or psychiatric or psychopathology or emotion\$ or well-being or wellbeing or distress*
3. *utili?\$ or help seeking or help-seeking or access or barrier\$*
4. 1 and 2 and 3
5. Remove duplicates from 4
6. Limit 5 to English language
7. Limit 6 to human
8. Limit 7 to humans

Searches were sporadically rerun to identify papers that had been published subsequent to the original search up to 14 February 2011.

The original search of the MEDLINE, EMBASE and PsycINFO databases returned 731 records. The same search strategy was used in the ScienceDirect database. A search of the SAGE database (from January 1879 to July 2009) was conducted using the following search terms: *migrant or immigrant or migrants or immigrants AND mental or psychological or psychiatric or psychopathology or emotional or well-being or wellbeing or distress AND utilise or utilisation or utilize or utilization or access or barrier or barriers* in keywords. Three further articles were identified, but were not thought to be relevant: two did not examine attitudes toward accessing mental health services, and one involved older migrants.

Inclusion and exclusion criteria. Inclusion and exclusion criteria were as follows.

Inclusion criteria. Included studies met the following criteria:

1. Qualitative or quantitative studies examining migrant attitudes toward seeking professional help for distress.
2. English language.
3. At least 90% of the migrant group were first generation.

Exclusion criteria. The following types of papers were excluded:

1. Literature reviews, reflective papers, theoretical papers, doctoral theses, and comments on the literature.
2. Papers about development of measures.
3. Case studies, case series, and reports of interventions or services for migrants.
4. Quantitative studies providing descriptive data only.
5. Studies where the majority of participants were children or adolescents, older adults (i.e., over 65 years), asylum seekers, or refugees.
6. Studies which did not report whether migrants were first generation and did not report length of residence data, meaning that it was impossible to establish what proportion of participants, if any, were first generation.

7. Studies with obvious methodological errors, such as describing the participants as migrant community members when this was not actually the case.²³
8. Studies that focused exclusively on domestic violence, substance abuse, or somatic symptoms.

Abstracts were screened using the inclusion and exclusion criteria. Any studies that clearly did not meet these criteria were excluded at this stage. Full-text articles were obtained for the remaining studies and were read in detail. Only papers that met all of the inclusion and exclusion criteria were retained at this stage for inclusion in the systematic review.

Methods of critical appraisal of quantitative studies. Many tools exist for evaluating the quality of intervention studies (e.g., Higgins & Green 2009).²⁴ However, van Gerwen, Franc, and Rosman²⁵ highlight that there is a lack of consensus on how cross-sectional studies of attitudes should be evaluated. Therefore, quality criteria were adapted from Greenhalgh,²² Pettigrew and Roberts,²⁶ and relevant systematic reviews of quantitative studies of attitudes.^{27,28,29} Issues generally considered important in the assessment of quality in cross-sectional studies included adequate description of methods of sample selection, inclusion and exclusion criteria, and participant characteristics; adequate sample size; representativeness of sample; reliability and validity of measures utilized; and appropriateness of methods of data analysis.

Given the small number of quantitative studies meeting the inclusion and exclusion criteria, none were excluded on the basis of quality. Excluding studies on the basis of quality would have meant that the diversity of migrant groups included in the review would have been restricted, making it more difficult to compare and contrast attitudes across migrant groups. Pettigrew and Roberts²⁶ suggest that conducting a sensitivity analysis can help to determine the impact of including or excluding studies of varying levels of methodological quality, by examining whether the results would differ if only studies above a certain threshold of methodological quality were included. In the current review, it was assumed that a quality rating of four or above indicated adequate quality. Only one study (12.5%)²¹ fell below this threshold. A decision was made not to exclude it as it appeared to address some interesting issues and did not significantly alter the conclusions reached in the review.

Methods of critical appraisal for qualitative studies. Quality criteria for qualitative studies were based on the work of Charmaz,³⁰ Flick,³¹ Glaser and Strauss,²¹ and Mays and Pope.³² Factors that are considered particularly important when assessing the quality of qualitative research include adequate description of sample selection and participants; systematic methods of data analysis; transparency of methods; credibility and cohesiveness of results; inclusion of analytic commentary; triangulation of sources; participant involvement; and researcher reflexivity.

Due to the heterogeneity of samples and methods, no studies were excluded on quality grounds in order to represent the depth and breadth of the literature. Instead, a sensitivity analysis was conducted to determine whether the results of the review would have been different had strict quality inclusion criteria been adhered to.²⁶

Methods of synthesis for quantitative studies. It was not considered feasible to attempt a meta-analysis of the quantitative studies: this was due to the diversity of

variables investigated and measures used rather than heterogeneity in outcome. Instead, variables that were shown to be significantly associated with help-seeking attitudes in at least one study were compared across studies, with a view to identifying consistencies, inconsistencies, and potential reasons for them.

Methods of synthesis for qualitative studies. Dixon-Woods, Booth, and Sutton³³ highlight the importance of making methods explicit in the synthesis of qualitative research, including a description of characteristics of papers, and methods of searching, appraisal, and synthesis. The constant comparative method was used in the synthesis of qualitative studies; Glaser and Strauss²¹ argue that this method can be appropriately applied in the examination of existing literature. This method involves searching for incidences of similar phenomena across studies, allowing for consideration of similarities and differences.³⁰ The analysis was conducted by the first author. NVivo 8 (QSR, 2008) software was used to assist in the analysis of the data. The first level of analysis included extracting major themes from each of the studies. These themes were coded by arranging them into conceptually similar categories. Conceptually significant and frequently occurring themes were used to categorise data; this process corresponded to the notion of focused coding described by Charmaz.³⁰ Frequent reference was made to the original papers to ensure that themes were categorised correctly according to their content. Any themes that appeared in only one study and that appeared to represent issues of marginal importance were discarded at this stage. Finally, categories were organised into over-arching themes with a high degree of explanatory power. This level of coding corresponded to theoretical coding as described by Charmaz.³⁰ Codes at this level help to integrate categories in terms of their relationships to each other. Finally, all papers were re-read in full to check the veracity of the analysis and to ensure that important issues had not been missed.

Results

This section will present the results of the literature search, critical appraisal of studies, and a synthesis of their results.

Literature search. Of the 734 papers identified in the original electronic search, 51 papers were considered potentially relevant upon reading the abstracts and were read in full. Of these, 31 did not meet the inclusion and exclusion criteria. This left 20 relevant papers. References of included papers were checked for potentially relevant studies; none of the 34 papers identified as potentially relevant were found to meet the inclusion and exclusion criteria when the papers were read in full. It was not possible to access two papers that may have been relevant, although it was considered unlikely that they would be. Fifty-four further papers were identified through re-running the searches, four of which were included. This led to a total of 23 papers being included in the review. A flowchart of studies included and excluded at each stage is shown in Figure 1 following guidelines by Moher, Liberati, Tetzlaff *et al.*³⁴

Critical appraisal of quantitative studies. Table 1 presents quality ratings for the included quantitative studies. The main methodological problems in the studies reviewed were inadequate description of inclusion and exclusion criteria, and a lack of representativeness and generalizability. In part, this is because it is often unfeasible

Identification

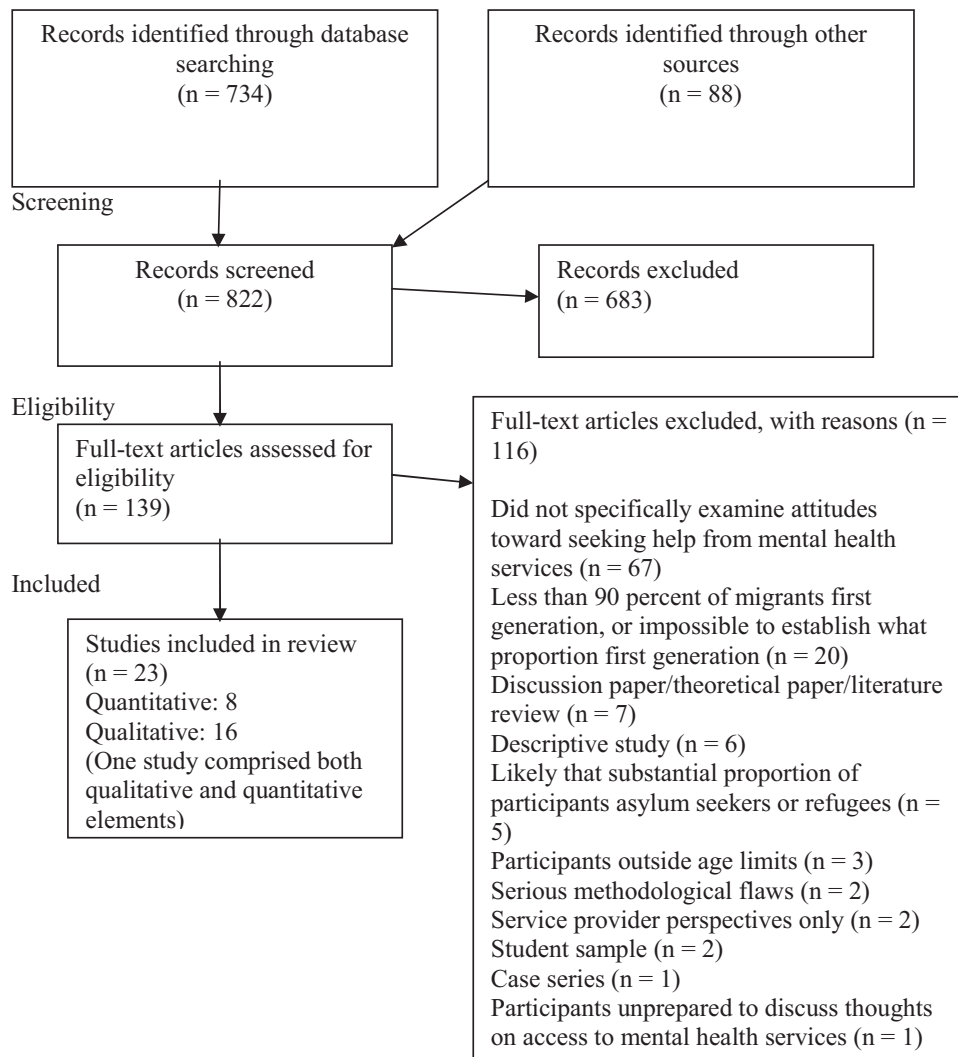


Figure 1. Flowchart of included studies.

to gain a representative sample in hard-to-reach populations, and methods such as convenience and snowball sampling provide the best opportunity to recruit a relevant sample.³⁵ However, caution is required in applying these findings to other migrants from the same cultural groups, and they cannot necessarily be considered applicable to other migrant groups. Another common problem was that all studies used at least some measures for which psychometric properties were not established. In some instances, this may have been because appropriate measures have not yet been developed for use with particular migrant groups, necessitating a degree of flexibility. However, in several studies, measures constructed *ad hoc* involving single items or very few items were used with little consideration of their psychometric validity.

Table 1.

QUALITY ASSESSMENT OF INCLUDED QUANTITATIVE STUDIES (N=8)^a

Authors	Adequate description of methods of sample selection	Description of inclusion and exclusion criteria	Adequate description of participants	Representativeness/ generalizability	Reliable and valid measures	Adequate sample size^b	Evidence of appropriate analytic methods	Total	Above adequate quality threshold?
Barry and Grilo	1	0	1	0	0.5	1	1	4.5	YES
Barry and Mizrahi	1	0	1	0	0.5	1	1	4.5	YES
Bassaly and Macallan	1	0	0	0	0	0	0	1.0	NO
Cabassa and Zayas	1	0.5	1	0	0.5	1	1	5.0	YES
Fung and Wong	1	1	1	0	0.5	1	1	5.5	YES
Knipscheer and Kleber	1	0.5	1	0	0.5	1	1	5.0	YES
Knipscheer and Kleber	1	0.5	1	0	0	1	1	4.0	YES
Mo, Mak and Kwan	1	0.5	1	0	0.5	0	1	4.0	YES
PERCENTAGE OF STUDIES ABOVE ADEQUATE QUALITY THRESHOLD									
									87.5%

^a 1 = Yes; 0.5 = Partially; 0 = No.

^b Calculated using G*Power3 if data not supplied in paper.

Critical appraisal of qualitative studies. Table 2 presents quality ratings for the included qualitative studies. One of the most important problems identified in the qualitative literature was a lack of transparency in research methods, making it difficult to form firm conclusions about the robustness of analyses. Furthermore, few authors reflected on their own role in the process, making it difficult to establish the extent to which their own perspectives and values influenced their analysis. Only three studies took measures to ensure participant involvement in the research process, and few used triangulation. However, it was felt that the latter two issues affected the quality of the data to a lesser extent than the former.

The sensitivity analysis suggested that all studies scoring five or above enhanced the depth of analysis. Ten studies (62.5%) achieved scores above this threshold for adequate methodological quality. With the exception of studies by Jirojwong and Manderson³⁶ and Martinez Pincay and Guarnaccia,³⁷ those with a quality rating of four or less were not considered to expand the comprehensiveness or richness of the analysis.

Synthesis of quantitative studies. Characteristics and key findings of included quantitative studies are presented in Table 3. The following section summarises factors that were found to be significantly associated with help-seeking attitudes in the studies reviewed.

Cultural adaptation. Willingness to seek psychological help was predicted by several measures of ethnic and cultural identity in two studies of East Asian migrants in the U.S. using the same sample.^{38,39} These included rejection of heritage cultural values and adoption of host cultural values as measured by the East Asian Acculturation Measure,⁴⁰ and construing the self in terms of social relationships on the Self-Construal Scale.⁴¹ Willingness to seek psychological help was inversely predicted by interpersonal distance as measured by the East Asian Ethnic Identity Scale.⁴² Further, a tendency to conceal emotions and personal information from others on the Guarded Self-Disclosure Scale⁴³ inversely predicted willingness to seek psychological help. Greater English fluency was also associated with more positive attitudes toward help-seeking.³⁸

In a sample of Southeast Asian migrants in Canada,⁴⁴ stronger identification with mainstream culture on the Vancouver Index of Acculturation⁴⁵ predicted more favourable attitudes toward seeking psychological help on the Attitudes Toward Seeking Professional Psychological Help Scale⁴⁶ (ATSPPHS) in Taiwanese and Korean participants, but not in participants from Hong Kong, China, or Vietnam. Identification with heritage culture was not significantly associated with attitudes toward help-seeking.

Mo, Mak, and Kwan⁴⁷ assessed identification with host and heritage culture using a measure derived from the General Ethnicity Questionnaire⁴⁸ in a sample of Chinese migrants in Hong Kong. Identification with host culture positively predicted amenability to seeking help from mental health professionals. Identification with heritage culture was not associated with help-seeking attitudes.

No association was found between ethnic identity and help-seeking attitudes in a study of Hispanic migrants by Cabassa and Zayas⁴⁹ using the Bidimensional Acculturation Scale for Hispanics,⁵⁰ which dichotomously categorises acculturative identity into unassimilated or bicultural identity.

Bassaly and Macallan⁵¹ measured acculturation using an adapted version of the Cuban Ethnic Attitudes Questionnaire⁵² in a sample of Polish migrants in the UK and attitudes

Table 2

QUALITY ASSESSMENT OF INCLUDED QUALITATIVE STUDIES (N=16)

Authors	A	B	C	D	E	F	G	H	I	J	TOTAL	Above adequate quality threshold?
Ahmad, Shik, Vanza <i>et al.</i>	1	1	1	0	1	1	0	1	1	0	7	YES
Ahmad, Shik, Vanza <i>et al.</i>	1	1	1	0	1	1	0	1	1	0	7	YES
Bassaly and Macallan	1	1	1	0	1	Couldn't tell	0	0	0	0	4	NO
Blignault, Ponzio, Ye <i>et al.</i>	1	1	1	0	1	1	1	1	0	0	7	YES
Chiu, Ganesan, Clark <i>et al.</i>	0	0	1	0	1	1	1	0	0	0	4	NO
Chung	0	0	0	0	1	1	1	0	0	0	3	NO
Hussain	1	0	1	0	1	1	1	1	0	1	7	YES
Jirojwong & Manderson	0	1	0	0	1	1	0	1	0	0	4	NO
Li and Browne	1	1	1	0	1	1	1	0	0	0	6	YES
Martinez Pincay and Guarnaccia	0	1	1	0	1	1	1	0	0	0	5	YES
Reitmanova and Gustafson	1	1	0	0	1	1	0	0	0	0	4	NO
Reitmanova and Gustafson	1	1	0	0	1	1	0	0	0	0	4	NO
Shin	1	1	1	0	1	1	1	1	0	0	7	YES
Tabora and Flakerud	1	1	1	1	1	1	1	1	1	0	9	YES
Whitley, Kirmayer and Groleau	1	0	1	0	1	1	1	0	0	1	6	YES
Wu, Kviz and Miller	1	1	1	0	1	1	0	1	0	0	6	YES
PERCENTAGE OF STUDIES ABOVE ADEQUATE QUALITY THRESHOLD												
												62.5%

A = Description of sample selection; B = Sufficient description of participants; C = Systematic method of data analysis; D = Sufficient transparency; E = Credible results; F = Well-integrated findings; G = Analytic commentary; H = Triangulation; I = Participant involvement; J = Researcher reflexivity

Table 3.

CHARACTERISTICS AND KEY FINDINGS OF INCLUDED QUANTITATIVE STUDIES (N=8)

Authors	Relevant research objectives	Participants	Age Mean (SD) ^a	LOR Mean (SD)	Gender	Methods	Key Findings
<i>North America</i>							
Barry and Grilo	To examine cultural, psychological, and demographic correlates of participants' willingness to use psychological services	170 East Asian migrants in the USA	28.4 (6.0)	7.5 (6.3)	52% male	Questionnaire study; convenience sampling; correlations and regression analysis	Willingness to seek psychological help predicted by assimilated cultural identity, lesser interpersonal distance, female gender, older age, shorter length of residence, and greater English fluency.
Barry and Mizrahi	To examine associations between guarded self-disclosure and willingness to seek psychological services.	<i>Same sample as Barry and Grilo</i>	<i>Same sample as Barry and Grilo</i>	<i>Same sample as Barry and Grilo</i>	<i>Same sample as Barry and Grilo</i>	Questionnaire study; convenience sampling; correlations and regression analysis	Willingness to seek psychological help negatively predicted by self-concealment.
Fung and Wong	To examine the relationship of casual beliefs, perceived service accessibility, and attitudes toward seeking mental health services	1,000 South East Asian migrants in Canada	42.0 (11.4)	9.3 (6.5)	100% female	Questionnaire study; convenience sampling; regression analysis	Willingness to seek psychological help predicted by: perceived accessibility of services in participants from China, Taiwan, Korea, and Vietnam; identification with host cultural in participants from Taiwan and Korea; conceptualising psychological problems as related to stress in participants from Hong Kong; inversely predicted by supernatural conceptualisations in participants from Hong Kong and Taiwan.

(continued on p. 105)

Table 3. (*continued*)

Authors	Relevant research objectives	Participants	Age Mean (SD) ^a	LOR Mean (SD)	Gender	Methods	Key Findings
Cabassa and Zayas	To examine the role that illness perceptions, attitudes toward depression treatments, and subjective norms play in intentions to seek depression care	95 Hispanic migrants attending a primary care clinic in the USA	30 (10)	6 (5)	25% male	Questionnaire and vignette study; convenience sampling; regression analysis	Intentions to seek formal services for psychological issues were predicted by conceptualising target's problems as depression, favourable views of healthcare providers' interpersonal skills, and a belief that their family would support this decision.
<i>Europe</i>							
Bassaly and Macallan	To determine relationships between attitudes toward seeking psychological help, cultural identity, and resilience	100 Polish migrants in the UK	Modal age group: 26–35 years	Modal LOR: 1–3 years	17% male	Questionnaire study; convenience and snowball sampling; regression analysis	Identification with Polish cultural inversely predicted overall willingness to seek psychological help, recognition of need for psychological help, comfort in disclosing personal information, confidence in psychological services, and expectations of being accepted for psychological intervention. Identification with British culture inversely predicted ability to tolerate stigma associated with seeking psychological help and expectations of being accepted for psychological intervention.

(continued on p. 106)

Table 3. (*continued*)

Authors	Relevant research objectives	Participants	Age Mean (SD) ^a	LOR Mean (SD)	Gender	Methods	Key Findings
Knipscheer and Kleber	To investigate migrant attitudes toward consulting agencies for mental health care when confronted with distress	292 Moroccan and Turkish migrants in the Netherlands	36.4 (11.0)	17.5 (7.8)	63.4% male	Structured interviews; purposive sampling; logistic regression analysis	Willingness to consultant community mental health services predicted by lower educational levels and shorter length of residence.
Knipscheer and Kleber—Study 1	To investigate whether migrants would consider consulting agencies for mental health care when they experience distress	292 Surinamese migrants in the Netherlands	34.9 (10.5)	17.3 (8.5)	56% male	Structured interviews; purposive sampling; logistic regression analysis	Willingness to consult a mental health professional predicted by longer length of residence.
<i>Asia</i>							
Mo, Mak and Kwan	To examine the relative contribution of acculturation and enculturation to the likelihood of help-seeking from mental health professionals	131 Chinese marriage migrants in Hong Kong recruited from community service agencies	35.6 (7.4)	2.0 (2.2)	100% female	Questionnaire design; cross-sectional sampling; regression analysis	Willingness to seek help from mental health professionals predicted by higher educational levels, higher household income, and acculturated cultural identity.

^a If means and SDs not reported, ranges given instead.
LOR= Length of Residence

toward seeking psychological help using the ATSPPHS.⁴⁶ They found that Polish culture identification inversely predicted willingness to seek psychological help, recognition of the need to seek help, comfort in disclosing personal information, confidence in psychological services, and expectations of being accepted for psychological assistance. Identification with British culture predicted views that seeking psychological help was stigmatizing and greater doubts about being accepted for psychological assistance.

Length of residence might be considered as a proxy measure of acculturation.⁵³ More favourable attitudes toward help-seeking were associated with shorter length of residence in East Asian migrants in the USA.³⁸ In contrast, longer length of residence was associated with more favourable attitudes toward help-seeking in migrants from Surinam in the Netherlands.⁵⁴ No association was found between length of residence and help-seeking attitudes in Turkish or Moroccan migrants in the Netherlands.⁵⁵

Demographic characteristics. Gender. In Barry and Grilo's sample of East Asian migrants,³⁸ female gender significantly predicted greater willingness to seek psychological help. However, no association between these variables was found in Latino migrants in the USA⁴⁹ or in Turkish, Moroccan and Surinamese migrants in the Netherlands.^{54,55}

Age. Being older predicted willingness to seek psychological in East Asian migrants in the U.S.³⁸ However, age was not associated with help-seeking attitudes in a sample of Southeast Asian migrants in Canada,⁴⁴ Chinese migrants in Hong Kong,⁴⁷ or Latino migrants in the U.S.⁴⁹

Education. Higher educational levels were associated with more favourable attitudes toward help-seeking in Latino migrants in the U.S.⁴⁹ and Southeast Asian migrants in Canada.⁴⁴ No association between these variables was found in a sample of Chinese migrants in Hong Kong.⁴⁷

Socioeconomic status. Higher socioeconomic status predicted more favourable attitudes toward seeking psychological help in a sample of Chinese migrants in Hong Kong.⁴⁷ However, no association was found between these variables in Latino migrants in the U.S.⁴⁹ or in Turkish and Moroccan migrants in the Netherlands.⁵⁵

Distress. The effect of explanatory models of distress on attitudes toward seeking psychological help was investigated in two studies. Using the Mental Distress/Illness Explanatory Model Questionnaire,⁵⁶ Fung and Wong⁴⁴ found that attributing emotional problems to stress predicted ATSPPHS scores for participants from Hong Kong, but not in those from China, Taiwan, Korea, or Vietnam living in Canada. Attributing distress to supernatural causes inversely predicted ATSPPHS scores for participants from Hong Kong and Taiwan, but not for participants from other regions. Physiological attributions were unrelated to help-seeking attitudes across all groups. A positive association was also found between perceptions of appropriateness of services to migrant needs and help-seeking attitudes in all participants except those from Hong Kong.

In the U.S., Cabassa and Zayas⁴⁹ found that Latino migrants' identification of a problem presented in a vignette as depression significantly predicted amenability to seek formal assistance if faced with a similar problem.

Severity of distress did not appear to predict attitudes toward seeking psychological help in studies that examined this.^{38,49}

Synthesis of qualitative studies. All qualitative studies included in the review were conducted in North America, the UK, and Australia. Characteristics of included quali-

tative studies and themes arising are presented in Table 4. This section will present a synthesis of the main themes arising from the included qualitative studies.

Three main themes were identified in the qualitative literature: logistical barriers; cultural mismatch between services and participants; and preferences for assistance from alternative sources. Table 5 illustrates which studies contributed to each of the themes.

Logistical barriers. The most commonly cited barriers included insufficient knowledge and information,^{37,57–66} financial barriers and lack of health insurance,^{37,57–60,62,64,65,67} difficulties with location of services and transport,^{37,58,59,61,62} long waiting times,^{60,64,65} and lack of time.^{59,61} Other reported concerns included concerns about immigration status being discovered,³⁷ service constraints,⁶⁶ and concerns about entitlement to help.⁵¹

Cultural mismatch between services and participants. This theme comprised four categories: language and communication difficulties; conceptualisation of problems; lack of cultural understanding; and dissatisfaction with services.

Language barriers were frequently reported by participants across studies.^{36,37,51,59–66} Information was not necessarily available in participants' languages. Further, participants found it difficult to communicate with health service providers, who often did not speak their language. Communicating about sensitive emotional matters appeared to be particularly challenging for participants. On occasion, emotional expressions did not have a direct equivalent in English, which could lead to misunderstandings. Using interpreters was also said to present difficulties due to concerns about confidentiality within small ethnic communities.

Participants' understanding of emotional difficulties did not necessarily conform to Western models.^{37,57,60,61,63,67,68} They frequently attributed distress to challenging life circumstances and difficulties associated with the experience of migration. On occasion, emotional difficulties were attributed to spiritual causes. For instance, Hussain's⁶⁸ Muslim participants viewed distress as a punishment from God for perceived sins. Further, among certain cultural groups, such as Chinese participants, health was viewed as a holistic state of equilibrium involving both body and mind; for them, having separate mental health services was not seen to make sense.

Service providers were often seen to lack sensitivity and understanding of pertinent cultural and religious issues.^{37,51,58,59,64,65,66} Some participants from Eastern cultures also expressed discomfort at direct style of communication adopted by Western providers. In a few studies, participants reported direct experiences of discrimination, such as being belittled by service providers. Others perceived providers as being "cold" or as disliking them.

These factors could lead to dissatisfaction with, and distrust of, services.^{37,60,63,65,66,67,69} In several studies, participants also expressed views that service providers were overly keen to prescribe pharmaceutical medications; this was perceived negatively. The lack of a cultural tradition of psychotherapy in certain cultures, such as Chinese cultures, could also lead to talking therapies being rejected as a relevant form of assistance. Talking therapies appeared more congruent with other cultures, such as Latino.³⁷

Preferences for other sources of assistance. Categories included in this theme included preference to cope with problems independently; preferences for seeking help from informal resources or traditional healers; importance of culturally determined social

Table 4.

CHARACTERISTICS OF INCLUDED QUALITATIVE STUDIES AND THEMES IDENTIFIED (N=16)

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods	Themes Identified
<i>North America: Asian Migrants</i>							
Ahmad, Shik, Vanza <i>et al.</i>	To elicit experiences and beliefs about major health concerns	24 South Asian migrants to Canada	34 (18–69)	1.5 years	100% female	Focus groups; convenience sampling; constant comparison	<ul style="list-style-type: none"> • Appraisal of mental health problems • Stress-inducing factors (loss of social support, economic uncertainties, downward social mobility, mechanistic lifestyle, barriers in accessing health services, lack of social health insurance, climate and food change) • Coping strategies (socialisation, preventative practices, self-awareness, and home country medicine or visit) • Health concerns after immigration (compromised mental health and dissatisfaction with health services) • Popular sources of health information before and after immigration (social networks, media, doctors, community links) • Barriers to health information (loss of social networks, language barriers, work demand and time, transport difficulties, limited knowledge) • Facilitators to health information (for benefit of children, perceived need of self-awareness) • Credibility of health information
Ahmad, Shik, Vanza <i>et al.</i>	To investigate health promotion strategies and factors associated with the uptake of health messages	22 Chinese and 24 Indian migrants (latter may be the same as those in Ahmad <i>et al.</i> , 2004a) to Canada	33.5 (18–69)	1.8	100% female	Focus groups; convenience sampling; constant comparison	<ul style="list-style-type: none"> • Health concerns after immigration (compromised mental health and dissatisfaction with health services) • Popular sources of health information before and after immigration (social networks, media, doctors, community links) • Barriers to health information (loss of social networks, language barriers, work demand and time, transport difficulties, limited knowledge) • Facilitators to health information (for benefit of children, perceived need of self-awareness) • Credibility of health information

(continued on p. 110)

Table 4. (continued)

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods	Themes Identified
<i>North America: Asian Migrants (continued)</i>							
Chiu, Ganesan, Clark <i>et al.</i>	To gain an understanding of how immigrants diagnosed with serious mental illness make treatment choices with respect to spirituality; to understand the treatment choices and needs of women from different immigrant groups	15 Chinese and 15 Indian immigrants to Canada	Chinese: 44 Indian: 48	Not reported	100% female	Purposive sampling; idiosyncratic methods of analysis	Three stage process of help-seeking identified 1. Identifying contributing factors (gender roles, access to resources, spirituality and belief systems) 2. Exploring resources (complementary and alternative therapies, spiritual strategies, religious practices, self-help activities, family closeness) 3. Living with choices (traditional healing practices, conventional medicine, integration of both conventional and alternative medicine, peace at heart)
Chung	To elucidate the interplay of immigrant-specific and sociocultural issues on help-seeking behaviour	31 Chinese immigrants in the USA attending mental health services following suicide attempts	Not reported	Not reported	Not reported	Narrative interviews; convenience sample; thematic analysis	<ul style="list-style-type: none"> • Issues of obligations and personal responsibility • Health issues • Mental health issues • Issues relating to suicide attempts • Modification of help-seeking behaviour through the positive influences of a supportive milieu • Failing personal obligation and responsibility in the recovery process

(continued on p. 111)

Table 4. (continued)

Authors	Relevant research objectives	Participants	Age Mean (SD)	IOR Mean (SD)	Gender	Methods	Themes Identified
<i>North America: Asian Migrants (continued)</i>							
Li and Browne	To explore barriers to accessing mental health services, formal and informal sources of help, and past experiences of interacting with health professionals	60 Asian migrants to Canada	41–43 ^a (12.2)	13 (9.79)	Approximately equal numbers of males and females	Semi-structured interviews; convenience and snowball sampling; content analysis	<ul style="list-style-type: none"> • Definitions of having mental health problems (feeling a lack of purpose in life, loneliness, having difficulties dealing with a new environment, anxiety, somatic illness, and being serious and untreatable) • Perceived barriers to accessing mental health services (poor English, culturally determined interpretations of mental illness, not knowing how to access services, racial discrimination, perception that health professionals did not like them) • Formal and informal sources of support for mental health issues
Shin	To examine help-seeking behaviours related to depression	57 Korean migrants in the USA; 13 community leaders	Migrants: 48.3 (27–67) Community leaders: 47.6 (18–76)	Migrants: 19.5 (4–34) Community leaders: 11.7	46% male	Focus groups and individual interviews; convenience sampling; idiosyncratic analytic methods	<p>Four subgroups of participants identified, representative of four stages of help-seeking:</p> <ol style="list-style-type: none"> 1. Self-help strategies 2. Help sought from informal sources 3. Help sought from formal services 4. Help sought from mental health services
Tabora & Flakerud	To examine beliefs about emotional distress and their effects on help-seeking behaviours	14 Chinese migrants to the USA and two key informants (also Chinese)	46.6 (10.4)	12.07 (8.73)	100% female	Focus groups; convenience, network and purposive sampling; constant comparison method	<ul style="list-style-type: none"> • Shame (“losing face must be avoided”) • Culture (“our cultural beliefs affect the course of treatment”) • Lack of utility (“the services do not meet our needs”) • Variety in practices (“some of us use Chinese medical treatments, and some of us use Western medical treatments”)

(continued on p. 112)

Table 4. (continued)

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods	Themes Identified
<i>North America: Asian Migrants (continued)</i>							
Wu, Kviz and Miller	To explore perceptions of barriers to seeking mental health services	27 Korean migrants to the USA (15 community members and 12 services providers)	Community members: 59.9 (7.3) Service providers: 44.6 (11.2)	Community members: 25.8 (7.4) Service providers: 20.7 (9.4)	100% female	Qualitative focus group design; convenience sampling; content analysis	<ul style="list-style-type: none"> Contextual barriers (stigma, lack of funding, lack of partnership with churches) Individual barriers (language, lack of family support, lack of transport, financial limitations, lack of time, lack of knowledge)
<i>North America: Hispanic Migrants</i>							
Martinez Pincay and Guarnaccia	To investigate cultural understanding of mental health and depression and barriers to care	94 Latino migrants to the USA	20–71	< 1 year to > 20 years	19% male	Focus group design using vignettes; convenience sampling; content analysis	<ul style="list-style-type: none"> Barriers to seeking mental health treatment (stigma of mental illness, problems with health insurance, financial concerns, transport difficulties, immigration status, lack of knowledge about where to seek help, language and cultural barriers, “coldness” of providers, lack of understanding of what mental health treatment involves) Attitudes toward treatment Attitudes toward providers
<i>North America: Caribbean Migrants</i>							
Whitley, Kirmayer and Groleau	To examine under-use of mental health services	15 West Indian migrants in Canada	Not reported	Not reported	27% male	Qualitative design using Narrative Interview; purposive sampling; idiosyncratic methods of analysis	<ul style="list-style-type: none"> Perceived over-willingness of doctors to prescribe pharmaceutical medications Perceived lack of time and dismissive attitude of physicians during previous doctor–patient interactions Belief in the curative power of non-medical interventions

(continued on p. 113)

Table 4. (continued)

Authors	Relevant research objectives	Participants	Age Mean (SD)	IOR Mean (SD)	Gender	Methods	Themes Identified
<i>North America: Mixed Migrant Sample</i>							
Reitmanova and Gustafson	To examine perspectives on availability and access to support services for mental health	8 migrants to Canada from 8 countries on 4 continents (no further details given)	Early 30s to mid 40s	3 to 10 years	25% male	Semi-structured interviews; convenience sampling; content analysis	<ul style="list-style-type: none">• Determinants of emotional well-being (support from family and friends, sufficient income, employment, freedom to practice religious beliefs and cultural traditions, physical environment, gender, coping skills, delayed use of mental health services)• Barriers to help-seeking (insufficient information about mental health and related services, long waiting times, financial concerns, perceived cultural mismatch between participants and healthcare providers)
Reitmanova and Gustafson	To explore perspectives on access to and utilization of primary mental health services	Same sample as Reitmanova & Gustafson (2009a)	Same sample as Reitmanova & Gustafson (2009a)	Same sample as Reitmanova & Gustafson (2009a)	Same sample as Reitmanova & Gustafson (2009a)m	Semi-structured interviews; convenience and snowball sampling; idiosyncratic analytic methods	<ul style="list-style-type: none">• Barriers to using mental health services• Lack of information• Language and literacy issues• Mistrust of primary mental health care services• Stigma associated with mental illness• Long waiting times• Lack of finances• Cultural and religious differences and insensitivity

(continued on p. 114)

Table 4. (continued)

Authors	Relevant research objectives	Participants	Age Mean (SD)	IOR Mean (SD)	Gender	Methods	Themes Identified
<i>UK: Polish Migrants</i>							
Bassaly & Macallan	To explore attitudes toward seeking and receiving psychological help	3 Polish migrants in the UK	32	3–32 years	100% female	Semi-structured interviews; convenience and snowball sampling; thematic analysis	<ul style="list-style-type: none"> • Ability to share problems with others • Usefulness of counselling • Doubts about the adequacy of counselling • Seeking help as a sign of weakness • Acknowledgement of own inability to cope • Need to persevere in difficulty • Language barrier • Similarity seen as culturally determined • Need for a similar frame of reference • Helpfulness and acceptance • Understanding of minority status • Concerns about accessibility of help • Concerns about entitlement to help
<i>UK: Pakistani Migrants</i>							
Hussain	To examine reasons for low voluntary uptake of statutory mental health services	33 Pakistani migrants to the UK	55–62	Not reported	48% male	Semi-structured interviews; purposive sampling; constant comparative analytic method	<ul style="list-style-type: none"> • Kismet: fate as the cause of distress • Sabr: endurance of distress as help seeking • Purdah: gender “modesty” and role-fulfilment as the determinant activity in distress and its amelioration • Izzet: honour and family protection as the measure of balanced mental health • “Peace of mind”: normal mental health and its cultural formulation

(continued on p. 115)

Table 4. (continued)

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods	Themes Identified
<i>Australia: Asian Migrants</i>							
Blignault, Ponzio, Ye <i>et al.</i>	To examine cultural variables, knowledge and attitudes toward mental health services, and perceived barriers to mental health care	9 Chinese migrants using mental health services, 13 Chinese migrant community members, 1 carer, 11 service providers in Australia	Patients: 36 Community members: 46	Patients: 11 Community members: 7	Patients: 89% female Community members: 69% female	Semi-structured interviews; convenience and snowball sampling; thematic analysis	<ul style="list-style-type: none"> • Understanding of mental health and distress • Barriers to mental healthcare (knowledge of services and help-seeking, communication difficulties, stigma, confidentiality, service constraints and discrimination)
Jirojwong and Manderson	To examine personal, social, and psychological adaptation	139 Thai marriage migrants in Australia, 6 resource people	38 (19–65)	2 months to 29 years	100% female	Structured interviews; accidental and snowball sampling; content analysis	<ul style="list-style-type: none"> • Inadequate information prior to migration • English proficiency • Social support and personal relationships

^a The paper states, ‘The mean age within each group ranged from 41–43 years old (SD=12.2).

Table 5.**CONTRIBUTION OF INDIVIDUAL STUDIES TO FINAL THEMES
(N=16)**

Study	Logistical Barriers	Cultural Mismatch	Other Preferences
Ahmad, Shik, Vanza <i>et al.</i>	✓	✓	✓
Ahmad, Shik, Vanza <i>et al.</i>	✓	✓	x
Bassaly and Macallan	✓	✓	✓
Blignault, Ponzio, Ye <i>et al.</i>	✓	✓	✓
Chiu, Ganesan, Clark <i>et al.</i>	✓	✓	✓
Chung	✓	✓	✓
Hussain	x	✓	✓
Jirojwong and Manderson	x	✓	✓
Li and Browne	✓	✓	✓
Martinez Pincay and Guarnaccia	✓	✓	✓
Reitmanova and Gustafson	✓	✓	✓
Reitmanova and Gustafson	✓	✓	✓
Shin	✓	✓	✓
Tabora and Flaskerud	✓	✓	✓
Whitley, Kirmayer and Groleau	x	✓	✓
Wu, Kviz and Miller	✓	✓	✓

✓ = theme represented in study
x = theme not discussed in study

roles; shame, stigma, and confidentiality; and help-seeking as a stage-determined process.

Across cultural groups, participants often valued self-reliance and expressed a preference for solving their difficulties independently.^{37,51,58,62,64,68} Some participants also chose to seek help from informal sources such as friends and family, or from traditional healers within their culture.^{36,37,57,58,60,62,63,67,68,53} Religious practices were also cited as a way of maintaining well-being and achieving relief from distress in a minority of studies.^{62,68,69} However, some participants felt that their family members did not understand their difficulties and were therefore unable to provide support or lacked time to do so.

For many participants, help-seeking behaviours were culturally determined and were strongly influenced by considerations concerning appropriate social roles.^{36,57,58,59,61,62,68} In some instances, help-seeking was seen as being more socially and culturally acceptable for women than for men.

Seeking help from formal services was often associated with shame, stigma, and fears about confidentiality.^{37,58,59,62–68} Being perceived as someone with mental health problems was seen as having the potential to bring shame on the family in Eastern cultures.

Several studies raised the possibility that the help-seeking process may involve a

number of stages.^{51,57,58,64} Participants would first try to resolve their difficulties independently, would then seek help from informal sources if this was ineffective, and would seek help from mental health services only as a last resort when their problems were viewed as affecting their ability to engage in valued social roles.

Discussion

The studies reviewed yielded some insight into factors influencing migrant attitudes toward seeking psychological help. Overall, the results of qualitative studies were more consistent than those of quantitative studies. Key findings of the review will be briefly summarised below. Next, strengths and limitations of both the literature and the current review will be considered. Finally, the clinical and research implications of the review will be discussed.

When considering the results of the studies included in the review, it is important to note the heterogeneity of samples. Migrants from a wide range of cultural groups were included, and some qualitative studies included mixed groups of migrants from different cultures. An advantage of this breadth of sampling is that issues can be compared across migrant groups. However, caution should be applied in interpreting the findings, as effects that are specific to certain cultural groups may be obfuscated and should not necessarily be generalised to migrant populations more broadly.

Broadly speaking, the results of the quantitative studies are consistent with the general population help-seeking literature: female gender, higher educational levels, and higher socioeconomic status appear to be associated with greater willingness to seek help, at least in some cultural groups.^{16,17,18,70} Additionally, the influence of explanatory models of distress and perceived social acceptability on help-seeking is congruent with the general population literature.^{16,18} Although findings in relation to age were inconsistent in this review, this is also the case in the broader literature.^{16,17,18} Therefore, the factors that influence help-seeking decisions in migrant and broader populations appear similar. However, this review highlights the additional importance of cultural issues (in particular, the association between cultural identification and help-seeking attitudes).

The vast majority of studies were conducted in North American (eight in the U.S. and eight in Canada). This raises the question as to whether similar results would be obtained in other countries. Mental health services in America are based on a diagnostic model due to health care being funded by insurance companies.⁷¹ Furthermore, this model means that economically disadvantaged people often cannot access necessary health care.⁷²

Sampling issues may have prevented income, age, and education effects from being identified in some of the studies reviewed: limited ranges for these variables may have prevented effects from being discovered. Identification of these effects may have been further attenuated by the decision to include only studies of working age migrants in the review, which is also likely to have restricted the age range of participants. Anderson, Brownlie, and Given⁷³ found that participants aged 25 to 59 held more favourable attitudes toward help-seeking from a therapist than those younger than 25 or older than 60.

The most consistent finding in the quantitative literature was an association between acculturation and help-seeking attitudes, although it is possible that the relative importance of identification with host and heritage cultures may vary across cultural groups. Salant and Lauderdale⁵³ highlight the lack of consensus on models and measurement of acculturation in immigrant populations: this was also apparent in the current review. Measuring relative identification with host and heritage cultural appeared to be a common approach. However, some measures focus on somewhat superficial factors such as language use, while others are broader in scope and attempt to measure variables such as cultural values. Nonetheless, in Asian cultures, it seemed that adopting, at least partially, some of the values and/or practices of the host country led to greater amenability to seeking psychological help. Some aspects of identification with heritage culture were inversely related to amenability to seek psychological help. Acculturation might be expected to increase with length of residence.⁵³ However, results regarding length of residence were inconsistent. This might relate to issues such as treatment accessibility and perceived need for help. The only study that found that shorter length of residence was associated with more favourable attitudes toward help-seeking concerned a student sample in North America,³⁸ who are likely to have had easy access to student counseling services. Gender differences were identified only for migrants from East Asian cultures, which have been characterised as promoting differentiated, hierarchical gender roles.^{74,75}

Measurement issues may have prevented associations between acculturation and help-seeking attitudes from being identified in other studies. For instance, Cabassa and Zayas⁴⁹ categorised participants as having either a bicultural or unassimilated identity, which may be an over-simplification. Similarly, Bassaly and Macallan⁵¹ found that bicultural identification was not associated with attitudes toward help-seeking.

Explanatory models of distress appeared to be associated with help-seeking attitudes. Cabassa and Zayas's⁴⁹ finding that participants were more likely to seek help from health services if they labeled a problem presented in a vignette as depression makes intuitive sense, and suggests that people may be more likely to seek help from sources which are congruent with their perception of their difficulties. Therefore, if problems are not considered to be psychological in origin, people may be more likely to seek help from alternative sources, such as family or traditional healers. Migrants across cultural groups may feel more inclined to seek help if services are perceived as culturally congruent and in line with their culturally determined conceptions of distress.

No association between severity of distress and help-seeking was found in quantitative studies. In contrast, the qualitative literature suggested that migrants would only seek when problems were severe. However, all quantitative studies reviewed included community samples who had not necessarily sought help from psychological services. Therefore, their levels of distress are likely to have been lower than in clinical samples.

The qualitative literature indicated considerable similarity in migrants' responses to distress and help-seeking decisions across cultures. Logistical barriers to accessing services were frequently identified in the qualitative literature reviewed, including lack of information, costs of services, and difficulties attending services. Similar barriers have been reported in the general population literature.¹⁶ However, these difficulties may be

exacerbated for migrants, who often have to balance childcare commitments with the demands of insecure, poorly paid jobs involving long or atypical working hours.^{76,77}

A common problem identified by the review was perceived cultural mismatch between participants' and services providers in terms of language and a lack of understanding of participants' culture. Service providers may make assumptions about the meaning of participants' presentation without understanding the cultural context. For instance, it has been suggested that Chinese people are more likely than people from Western cultures to somatize their distress.⁶⁰ However, Chinese people understand complaints of heart problems as expressions of emotional distress,⁷⁸ while Western clinicians might interpret them as representing somatization. Further, in Eastern cultures with a history of Taoism, distress is thought to result from imbalances within this system, such as between hot and cold elements.^{67,75,78} For instance, angry feelings are thought to result from excessive heat in the body; an appropriate remedy is thought to be avoiding spicy and fatty foods to restore emotional equilibrium.⁶⁷ This may mean that having separate services for physical and emotional difficulties would be difficult for these migrants to understand.

Furthermore, migrants' expectations of services appeared to be framed by cultural norms that were often contrary to Western psychotherapeutic practices; for instance, some participants hoped to form a close personal relationship with a helper.⁷⁹ This could lead to a perception of being misunderstood or rejected by therapists working from models which emphasise therapeutic distance and boundaries, such as psycho-dynamic therapy. Without a sufficient understanding of such issues, service providers risk alienating migrants by providing interventions that are culturally incongruent.

Many participants preferred to seek help from sources other than mental health services. A preference for dealing with problems independently or seeking help from one's immediate social circle in the first instance and reserving formal help-seeking for more severe situations has also been reported in general population samples.⁸⁰ However, the reasons for this may vary cross-culturally. While stigma is likely to play a role across cultures, this is likely to be particularly significant in those in which mental distress leads to substantially reduced social status or is seen to bring shame on the family.

The degree of consistency found across migrant groups in the qualitative studies reviewed in perceiving services to be culturally insensitive is noteworthy. This suggests that service providers tend to lack knowledge of minority ethnic and immigrant groups in general, and that this is a common experience for migrants regardless of country of origin. It is also consistent with the results of quantitative studies reviewed, which suggests that acculturation leads to greater amenability to seek help. Migrants may only perceive psychological services as relevant to them if they adopt the host culture's values (since mental health services do not appear to be able to meet their needs unless this occurs). This has serious ethical implications, as it suggests a lack of flexibility and cultural competence on the part of mental health service providers.

Strengths and limitations. *Strengths.* No previous systematic reviews of migrant attitudes toward seeking psychological help were identified in the literature. Therefore, this paper is the first attempt to integrate studies examining this construct. The inclusion of both qualitative and quantitative literature allows for a more comprehensive

understanding of relevant issues. The qualitative literature provides for a detailed and nuanced insight into migrant attitudes, while quantitative studies allow greater generalizability of findings in larger samples.

Limitations. An argument could be made that it is inappropriate to synthesize findings from such a diverse range of migrant groups. The scope of the review means that nuanced cultural facets of help-seeking may be obscured, and that issues pertinent to specific cultures may be overlooked. In addition to having different cultural values, health and social care systems vary considerably between countries. Therefore, migrant experiences are likely to differ depending on where they migrate to. Reasons for migration and immigration status may also affect attitudes toward help-seeking. For instance, literature suggests that illegal immigrants are less likely to seek help due to fears about the consequences of their status being discovered.⁸¹

It might be hypothesised that similarity between the values of host country and country of origin might lead to easier integration. In this instance, acculturation may be a less relevant factor than for individuals migrating between countries with strongly contrasting cultures. However, this is not borne out by the research evidence. Mo, Mak, and Kwan⁴⁷ studied women migrating from China to Hong Kong. Despite the geographical and cultural similarities between these groups, they found strong acculturation effects similar to those observed in other cultures, which they attribute to the subtle cultural differences to which migrants have to adapt. Similarly, Bassaly and Macallan's⁵¹ sample included participants migrating between two predominantly white, European, nominally Christian societies, namely Poland and the UK. Again, similar help-seeking patterns were found to those from Asian migrants to North America.

This is not to downplay the importance of cultural differences or diversity of cultural values between migrant groups. Nonetheless, a great deal of commonality was apparent in the qualitative literature, which suggests that there may be some fundamental factors which influence help-seeking attitudes in migrants which apply across cultural groups. Migrant attitudes toward seeking psychological help may be at least partially influenced by factors which apply across cultures or which are associated with the experience of migration itself.

Clinical and service implications. The most important clinical implication highlighted by the review is that across cultural groups and countries, migrants often appear to feel that services lack cultural sensitivity and are not able to meet their needs. Further, practical barriers such as clinic locations and opening times often prevented migrants from accessing services. In North American studies, costs also presented a barrier.

This calls attention to the need for clinicians to develop greater sensitivity to cultural issues. Although there is a great deal of rhetoric about culturally sensitive practice, including a section on cultural formulation in the DSM-IV-TR,⁸² the studies reviewed suggest that this does not necessarily translate into practice. Greater emphasis on cultural issues in training across disciplines—provided that this is not done in a *pro forma* manner—would be one way to tackle this problem. Further, individual clinicians have a responsibility to educate themselves about the cultural values of migrant clients with whom they work.

Sue and Sue⁸³ identify three core competencies for counselling in working with culturally diverse clients. First, therapists should aim to become aware of their own

assumptions, values and biases. They suggest that those training as mental health professionals should be encouraged to reflect upon their own cultural heritage, norms, values, and culture-bound goals. This process may be encouraged through experiential exercises and effective supervision. Second, therapists should seek to understand and accept the worldviews of culturally diverse clients. Although therapists' life experiences may differ from clients', therapists may be better able to empathise with this through a process of cultural role taking. This would involve acquiring both practical knowledge concerning clients' culture and an understanding of broader sociopolitical systems affecting clients' lives. Third, intervention strategies and techniques should be adapted to achieve cultural congruence. Many therapeutic effectiveness studies have failed to consider ethnicity or have included participants from predominantly White, Western samples. Sue and Sue⁸³ highlight that self-disclosure is unacceptable in certain cultural groups, and that socially disadvantaged groups may be disinclined to engage in talking therapies. Therapies developed within Western culture are likely to reflect dominant cultural values; for instance, Langman⁸⁴ suggests that behavioral therapies may reflect the Protestant values of their developers, where stoicism and practical solutions are valued. Some therapeutic approaches, such as Narrative Therapy, specifically aim to be applicable cross-culturally,⁸⁵ but tend to be assigned a lesser status within Western health systems emphasising evidence-based practice in line with positivist research traditions. Therapists should be prepared to modify their usual interventions when necessary to ensure that they are culturally appropriate. Adopting a curious stance about clients' experiences rather than imposing therapeutic models that may be culturally incongruent is likely to be helpful in this respect.

In addition, service developers should consider how services might be adapted to meet the needs of clients from migrant groups. In part, this might involve greater flexibility in terms of the locations and opening times of clinics. It is sometimes assumed in the literature that migrants should be educated in Western models of distress and encouraged to seek help from formal services.^{47,58} However, an important finding in the qualitative literature was that migrants often preferred to seek help from other sources and that seeking help from formal sources might in fact be associated with negative consequences. Therefore, providers might be well advised to think more creatively about how to meet the needs of migrant groups, perhaps through collaborative work with community migrant organisations.

Recommendations for future research. A difficulty in synthesising the quantitative literature was the diversity of measures adopted. Comparative analysis of results across quantitative studies would be facilitated by the adoption of similar assessment measures. The ATSPPHS⁴⁶ has been used in a number of studies, and appears to be a promising instrument. Most studies have measured acculturation along two dimensions—identification with host and heritage culture—and consistent adoption of this method would aid the synthesis of data from different studies. It would also be helpful for future quantitative research to include variables that have been found to have a significant association with help-seeking attitudes in previous studies to determine whether these findings are replicable within cultural groups, and whether the relative importance of these variables varies across cultures. Sophisticated statistical techniques such as structural equation modelling might be helpful in this regard. Future research

could also help to illuminate the similarities and differences in help-seeking attitudes across migrant groups and the cultural factors that are most influential in determining these.

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